PATIENT'S RIGHTS AND RESPONSIBILITIES

As a participant in this health insurance program, you have certain rights and responsibilities. By becoming familiar with them, you will be able to make the most of your health care. Our goals are to strengthen your confidence in a fair, responsive and high quality health care system, to provide effective mechanisms to address your concerns and to encourage you to take an active role in improving your health and health care.

The following is a summary of your rights and responsibilities.

You have the following rights:

- Considerate, respectful care from all members of the health care system.
- Non-discrimination consistent with state and federal law.
- To change plans annually.
- To a description of benefits presented in an understandable manner. Uniform Benefits are described in Section D of this booklet. Outlines of coverage for the Standard plans are found in Section G of this booklet. If you select one of the Standard plans, you will receive a certificate of coverage that describes your benefits. Your plan may also provide additional information regarding referral requirements, etc.
- To select a primary care physician and to have access to appropriate specialty care. You have the right to a referral to a non-plan specialist for covered services if there is not a plan specialist who is reasonably available to treat your condition.
- A woman has the right to have access to an OB/GYN provider.
- A woman has the right to a minimum hospital stay of 48 hours following a normal delivery of a child or 96 hours following a cesarean delivery. The physician, in consultation with the mother, may discharge the mother and baby prior to the expiration of the minimum stay.
- To have continuous, appropriate access to a provider for the remainder of that calendar year if the provider leaves the plan (other than for misconduct, retirement or a move from the service area). A woman in her second or third trimester of pregnancy has access to that provider until the completion of postpartum care. This right only applies to providers that are listed in the plan's provider directory available during the Dual-Choice Enrollment period.
- To have access to emergency care without prior-authorization from the plan. If it is not reasonably possible to use a plan hospital or facility, you have the right to obtain treatment at the nearest facility and have those charges covered by the plan as if you did use the plan hospital or facility (however, be aware of your responsibilities when emergency care is received).
- To participate with your provider in treatment decisions.
- To confidentiality of medical information.
- To execute a living will or durable power of attorney for health care if you are 18 years of age or older. These documents tell others what your wishes are in the event that you are physically or mentally unable to make medical decisions or choices yourself.
- To appeal any referral or claim denial through the plan's grievance process. This review will be conducted in a timely manner. Grievances related to care which is urgently needed must be reviewed by the plan within four working days. If you have exhausted all levels of appeal available through the plan you may submit a complaint to the Department of Employee Trust Funds, in care of the Quality Assurance Services Bureau. You will need to submit a complaint form (ET-2405). You also have the right to request a departmental determination if you believe that a plan did not comply with its contractual obligations.

In a health care system that protects patients' rights, it is reasonable to expect and encourage patients to assume certain basic responsibilities. Greater personal involvement in your care increases the likelihood of achieving the best outcomes and helps support quality improvement and a cost conscious environment.

You have the following responsibilities:

- During the Dual-Choice Enrollment period, to review the *It's Your Choice* book and information provided by your plan. This information is important to determine if your plan and/or your providers will continue to be available and whether your current plan continues to best meet your needs for the following calendar year.

- To submit your application for coverage prior to the end of the enrollment period if you select a different plan during the Dual-Choice Enrollment period.
- To select a primary care physician who will oversee your total health care and to make a reasonable effort to establish a satisfactory patient/physician relationship.
- To become involved in your treatment options and/or treatment plan.
- To become knowledgeable about your health insurance coverage and your health plan, including covered benefits, limitations and exclusions and the process to appeal coverage decisions. If you are covered under an HMO or preferred provider plan, to also become knowledgeable about the plan's rules regarding use of network providers, prior authorizations and referrals.
- To authorize the release of relevant personal or medical information necessary to determine appropriate medical care, to process a claim or to resolve a dispute.
- To notify your plan by the next business day, or as soon as reasonably possible, if you receive emergency or urgent care from a non-plan provider.
- To promptly report any family status changes to your payroll representative (or ETF if you are an annuitant or continuant). These changes include marriage, divorce, death, a birth or adoption or a dependent child losing eligibility. You should also report address or name changes, a change in your primary care provider and Medicare eligibility.
- To respond to the plan's annual questionnaire on dependent eligibility if you have a dependent child who is at least 19 years of age and is a full-time student or is disabled. Coverage for dependents could be lost if the questionnaire is not returned to the plan.
- To notify your plan if you obtain or lose other health insurance.
- To submit claims to the plan in a timely manner, if applicable.
- To use the plan's internal grievance process to address concerns that may arise.

NOTIFICATION OF STATE AND FEDERAL REQUIREMENTS

➔ **INDEPENDENT REVIEW:** In addition to the internal grievance process that all health plans are required to provide, 1999 Wisconsin Act 155 requires all health plans to have an independent review procedure for review of certain decisions. These include denial of, or refusal to pay, for treatment that the insurer considers to be experimental, not medically necessary or appropriate or not the proper level of care or health care setting. The amount or expected cost of treatment must exceed $250 and a $25 fee is required with the request for independent review. The fee will be refunded when the participant prevails.

The Office of the Commissioner of Insurance (OCI) oversees this process, which has been in place since mid-2002. Contact OCI at (800) 236-8517 or your plan if you have questions about the independent review law.

➔ **HIPAA/PRE-EXISTING CONDITIONS:** The federal Health Insurance Portability and Accountability Act (HIPAA), effective January 1, 1998, is intended to make it easier for employees to change jobs by limiting waiting periods for coverage of pre-existing health conditions.

Under this health insurance program, employees who did not enroll for coverage when first offered but later enroll are limited to coverage under the Standard Plan with a 180-day waiting period for pre-existing conditions. As a non-federal, self-insured governmental plan, HIPAA allows this policy to continue. The Group Insurance Board has determined that this is necessary to avoid potential anti-selection. There are certain situations where the employee may enroll as a late enrollee without these restrictions, such as loss of other group coverage, marriage and birth or adoption of a child. (See **Other Enrollment Opportunities** in Section C)

➔ **HIPAA/PRIVACY, ELECTRONIC TRANSACTIONS STANDARDS, AND SECURITY:** HIPAA's administrative simplification rules are intended to simplify and streamline the healthcare claims and payment process through the implementation of national standards. The rules also require that your health information be protected from unauthorized use or disclosure. The three components of the rules are privacy, electronic data transaction standards, and security. The privacy rule came into effect on April 14, 2003, and establishes limits on how your health information can be used and disclosed. The transaction standards rule, which sets out uniform methods for conducting electronic

transactions, is effective on October 16, 2003. The security rule requires safeguards for health information maintained in electronic form, and is effective on April 21, 2005.

The DETF is covered by HIPAA by virtue of the Group Insurance Board's Standard Plans that are administered by DETF. As a covered entity, the DETF must comply with the applicable HIPAA regulations. A Notice of Privacy Practices (NPP) was sent out to all members of the Standard Plans in April 2003 and is posted on the DETF web site. If you have insured health coverage from a Health Maintenance Organization (HMO) you should have received a NPP from your HMO.

If you have any questions about HIPAA and need further information, please contact the Department's Privacy Officer at 1-877-533-5020.

➔ **WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998** requires annual notification of coverage under this program for the following treatments in connection with a mastectomy:

Reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

➔ **COBRA: CONTINUATION OF COVERAGE PROVISIONS FOR THE GROUP HEALTH INSURANCE PROGRAM**

This notice is provided to meet Federally required notification for continuing your health insurance in the event that you or a covered dependent lose eligibility for coverage. Both you and your spouse should take the time to read this information carefully.

If active coverage is lost, the State Employees and Wisconsin Public Employers (local government) Group Health Insurance Programs have routinely permitted continuation of coverage for a:

- Retired employee
- Surviving spouse of an active or retired employee
- Surviving dependent child of an active or retired employee

The coverage for a retired employee and surviving spouse may be continued for life; the children may continue coverage for only as long as they meet the definition of a dependent child. This is not considered to be continuation of coverage as discussed below.

Current federal law, known as COBRA, is somewhat more broad and requires that this notification, regarding additional continuation rights, be given to you and your spouse at the time group health insurance coverage begins.

If you are the actively employed subscriber, you have the right to apply for continuation of coverage if you lose coverage because of a reduction in hours of employment or termination of employment (for reasons other than gross misconduct).

If you are the spouse of the subscriber (active or retired), you have the right to apply for continuation if you lose coverage for any of the following reasons:

1. The death of your spouse

2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment

3. Divorce from your spouse

Dependent children have the right to continuation if coverage is lost for any of the following reasons:

1. The death of a parent

2. A termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment

3. Parents' divorce; or

4. The dependent child loses dependent status.

The employee or a family member has the responsibility to inform the employer of a divorce or a child losing dependent status. Under the law, you must inform Employee Trust Funds that you want to continue coverage within 60 days from the termination of your current coverage or within 60 days of the date you were notified by your employer, of the right to choose continuation coverage, whichever is later.

Continuation coverage is identical to the former coverage, and you have the right to continue this coverage for up to three years from the date of the qualifying event (e.g., such as divorce or a dependent reaching the limiting age) that caused the loss of eligibility. However, your continuation coverage may be cut short for any of the following reasons:

1. The premium for your continuation coverage is not paid

2. You or a covered family member become covered under another group health plan that does not have a pre-existing conditions clause which applies to you or your covered family member or

3. You were divorced from a covered employee, subsequently remarry, and are covered under your new spouse's group health plan.

If you do not choose continuation coverage, your group health insurance coverage will end. You do not have to show that you are insurable to choose continuation coverage. However, you will be required to pay all of the premium (both your share and any portion previously paid by your employer). At the end of the three-year continuation coverage period, you will be allowed to enroll in an individual conversion health plan.

If you are an active employee, you or your dependents should contact your employer regarding continuation (including any changes to your marital status or addresses). If you are a retired employee, you or your dependents should contact our office regarding continuation, at toll free 1-877-533-5020 or (608) 266-3285 (local Madison).

Additional information may be found under **Continuation of Health Coverage** in Section C of this booklet.

➔ **NATIONAL MEDICAL SUPPORT NOTICE:** State and Federal law provides for a special enrollment opportunity for children in certain cases when ordered by a court. The enrollment opportunity is for eligible children who are not currently covered, and may provide for an enrollment opportunity not otherwise available. When the court orders such coverage for a child or children, a copy of the National Medical Support Notice should be attached to the application.